Coding Instructions for Confidential Cancer Reporting Form, continued

DATE OF INITIAL TREATMENT (MMDDYYYY) (1260) (ROADS pg. 179) (SEER pg. 121)

Enter the date (month, day, century and year) of initiation of the first cancer directed therapy for the cancer being reported. The first course of treatment is defined as cancer-directed treatment that is administered within the first four months after diagnosis or the first four months after the date treatment was started.

If the physician decides not to treat the patient, record the date of this decision as the date of initial treatment. The physician may decide not to treat the patient because of co-morbid conditions, advanced disease, or because the accepted management of the cancer is to observe until the disease progresses or until the patient becomes symptomatic.

> **EXAMPLE:** On February 12, 2001 the physician says that a low-stage prostate cancer patient will be observed until the Prostatic Specific Antigen (PSA) starts to rise. Enter 02122001 as the date of initial treatment.

If the patient refused treatment, record the date of this decision as the date of initial treatment. Record the date of death for autopsy-only cases. If the patient is diagnosed at the reporting facility and no further information is available record the date the patient was last seen at the reporting institution.

SCOPE OF REGIONAL LYMPH NODE SURGERY (1292) (ROADS pg. 192 (SEER pg. 127)

Document and code the "Scope of Regional Lymph Node Surgery" using the codes in Appendix A under the corresponding primary site. "Scope of Regional Lymph Node Surgery" defines the removal of regional lymph node(s). There is no minimum number of nodes that must be removed. If at least one regional lymph node was removed, the code for this field must be in the range of 1-5. If a regional lymph node was aspirated, code the regional lymph node(s) removed, NOS (1).

For head and neck sites, this field describes neck dissections. Codes 2-5 indicate only that a neck dissection procedure was done, they do not imply that nodes were found during the pathologic examination of the surgical specimen. Code the neck dissection even if no nodes were found in the specimen.

The codes are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.

> ***EXAMPLE***: A patient with a head and neck primary has a lymph node biopsy (code 1) followed by a limited neck dissection (code 3). Code the limited neck dissection (code 3). If a patient has a modified radical neck dissection, record code 4 (modified radical neck dissection) rather than the generic code "neck dissection, NOS" (code 2).

A list identifies the regional lymph nodes for each site in Appendix A. All other nodes are distant, and are coded in the data field "Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)".

Coding Instructions for Confidential Cancer Reporting Form, continued

If no cancer-directed procedure was performed code (0).

In the Scope of Regional Lymph Node Surgery field, the following priorities apply:

- Code 1-8 have priority over code 0 and 9.
- In the range of codes 1-8, the numerically higher code has priority.

NUMBER OF REGIONAL LYMPH NODES EXAMINED (1296) (ROADS pg. 193) (SEER pg. 128)

Document and code the "Number of Regional Lymph Nodes Examined" using the codes in Appendix A under the corresponding primary site, identified in the pathology report **DURING THIS SURGICAL PROCEDURE ONLY. DO NOT** add numbers of nodes removed at different surgical events.

If no regional lymph nodes are identified in the pathology report, code 00 even if the surgical procedure includes a lymph node dissection (i.e., modified radical mastectomy) or if the operative report documents removal of nodes.

This field is not cumulative and does not replace or duplicate the field "Regional Lymph Nodes Examined". Do not copy the values from one field to the other. They will not always be the same.

In the Number of Regional Lymph Nodes Removed codes, the following priorities apply:

- If lymph node surgery is done at the same time as definitive surgery, priority is given to the information connected with the most definitive surgery. Use the priority order listed under "Surgery of Primary Site" to determine the most definitive surgery of primary site.

- If lymph nodes surgery is done at a different time from the definitive surgery, priority is given to the code connected with the most definitive lymph node surgery. Use the priority order listed under "Scope of Regional Lymph Node Surgery" to determine the most definitive lymph node surgery.

FIRST COURSE OF TREATMENT

Cancer-directed therapy or definitive treatment is limited to procedures that normally affect, control, change, remove, or destroy cancer tissue of the primary or metastatic site. The **first course** of treatment is defined as cancer-directed treatment that is administered **within the first FOUR months** after diagnosis or the **first FOUR months** after the date treatment was started. Any and all types of **FIRST COURSE** definitive treatment administered at the reporting institution or elsewhere must be coded in the appropriate treatment field **and** documented in the **TREATMENT DOCUMENTATION** box.

EXCEPTIONS:

*1. If it is documented in the medical chart that the **planned** first course of therapy continued beyond or began after four months of initiation, include all as first course. Include a statement in the Treatment Documentation box stating it is planned as first course.*

Coding Instructions for Confidential Cancer Reporting Form, continued

*2. Should there be a change of therapy due to apparent failure of the original planned and administered treatment or because of the progression of the disease, the later therapy should be **excluded** from the first course and considered part of a **second** course of therapy.*

*3. For patients with a diagnosis of **leukemia**, the basic time period for first course of treatment is **four months** after the date of initiation of therapy. However, disregard all treatment administered to the patient after the lapse of the first remission. If no remission is attained during the first course of therapy, use the four-month rule.*

4. For patients with a diagnosis of prostate cancer, "watchful waiting" is considered first course treatment. If cancer-directed treatment is administered after disease progression, this would not be coded as first course treatment.

5. If a patient refused all cancer-directed treatment at the time of diagnosis and then decided to undergo treatment after disease progression, the treatment rendered would not be coded as first course.

DATE STARTED (MMDDYYYY) - SURGERY (1200) (ROADS pg. 179 and pg. 184) (SEER pg. 121)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day and year of the first cancer-directed surgery. If the exact date of cancer-directed surgery is not available, record an approximate date.

If two or more cancer-directed surgeries are performed, enter the date for the **first** cancer-directed surgery.

***EXAMPLE:** A patient was found to have a large polyp during a colonoscopy. Polypectomy(surgery code 26) September 8, 2000 confirmed adenocarcinoma of the descending colon. September 23, 2000 the patient underwent a left hemicolectomy (surgery code 40). The date of surgery would be recorded as 09082000, and the surgery code 40.*

If an **incisional** biopsy was performed followed by a resection two weeks later, enter the date for the resection as the date started. An incisional biopsy is a diagnostic procedure, **not** a cancer-directed treatment.

***EXAMPLE:** February 1, 2001 a patient had a fine needle aspiration of a right breast mass, consistent with infiltrating ductal carcinoma. February 15, 2001, the patient underwent a right modified radical mastectomy (surgery code 50) for Stage II disease.*

The date of surgery would be recorded as 02152001, and the surgery code 50.

***NOTE*:** If the chart contains information indicating the contralateral breast was not involved or removed, code the more specific surgery code of "51" (WITHOUT removal of uninvolved contralateral breast). This information is often documented in the History and Physical Summary and the removal or lack of involvement of the contralateral breast can be determined from the Operative and Pathology reports.

Coding Instructions for Confidential Cancer Reporting Form, continued

EXAMPLE: *February 16, 2001 a patient had an incisional biopsy of an enlarged mediastinal lymph node which was positive for adenocarcinoma of the right lung. February 27, 2001, a partial lobectomy (surgery code 31) and lymph node dissection was performed, both consistent with adenocarcinoma. The date of surgery is recorded 02272001, and the surgery code 31. The lymph node dissection would be documented and the fields for regional lymph nodes positive and regional lymph nodes removed coded appropriately.*

TYPE OF RX - SURGERY (1200, 1290, 1294, 1340) (ROADS pgs. 187-189) (ROADS pgs. 192-193) (SEER pgs.124-126)

Cancer-directed surgery is an operative procedure that actually removes, excises, or destroys cancer tissue of primary site or metastatic site. Surgery performed solely for the purpose of establishing a diagnosis/stage (exploratory surgery), the relief of symptoms (bypass surgery), or reconstruction are not considered definitive treatment. Brushings, washings, and aspiration of cells are not surgical procedures.

Guidelines in coding treatment:

Effective with **cases diagnosed January 01, 2001** and forward, the Site-Specific Surgery scheme for each primary site consists of **four data fields**.

- Surgery of Primary Site
- Surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)
- Number of Regional Lymph Nodes Removed
- Scope of Regional Lymph Node Surgery

NOTE**:** Code all the surgery data fields appropriately**.**

1. Document and code **SURGERY OF PRIMARY SITE** using the codes under the corresponding primary site found in **Appendix A**. A patient may have both cancer directed surgery and surgery of regional site and/or distant sites and lymph nodes. Document all surgical procedures and code the surgery of the primary site. Surgery to remove regional tissue or organs is coded in this field **only** if the tissue/organs are removed with the primary site in an **en bloc** resection. An en bloc resection is the removal of organs in one piece at one time.

   EXAMPLE: *A patient has a modified radical mastectomy. The breast and axillary contents are removed in one piece (en bloc). Surgery of primary site is coded as a modified radical mastectomy (50) even if pathology finds no nodes in the specimen.*

   NOTE: If no primary site surgical procedure was done, code "00".

Priority of Codes:

- Codes "10" - "90" have priority over code "99"
- Codes "10" - "84" have priority over codes "90" and "99"
- Codes "10" - "79" have priority over codes "80," "90" and "99," where "80" is site-specific surgery, not otherwise specified (for example, prostatectomy, NOS)

Coding Instructions for Confidential Cancer Reporting Form, continued

2. Document and code the **SURGERY OF OTHER REGIONAL SITE(S), DISTANT SITE(S), OR DISTANT LYMPH NODE(S)** using codes in Appendix A under the corresponding primary site. The codes for the regional sites and distant sites and distant lymph nodes include: Surgery of regional site(s), Dissection of distant lymph nodes, Surgery of distant site(s), and Surgery of distant site(s) with dissection of lymph node(s). Do **not** code surgery of regional lymph nodes in this field. A patient may have a surgical procedure of the primary site, regional and/or distant site(s) or lymph node(s) and a non cancer-directed procedure. **Document all that apply** and record the surgery and regional/distant codes in the appropriate fields.

   NOTE: An incisional biopsy is not considered cancer-directed surgery and should not be coded.

   EXAMPLE: *A patient has an excisional bx of a breast primary lesion. Patient elects to have an axillary lymph node dissection and radiation therapy. The axillary node dissection would be documented and coded appropriately in the regional nodes positive and the regional nodes examined fields. The excisional bx is a cancer-directed procedure and would be coded "12" in the surgery code field. Regional/Distant field would be coded "0" (not done).*

Priority of Codes:

- Codes *"1"* - *"8"* have priority over code *"0"* and *"9"*
- In the range of codes '1' - '8', the numerically higher code has priority

3. Document and code the **NUMBER OF REGIONAL LYMPH NODES REMOVED** identified in the pathology report **during this surgical procedure only. Do Not** add numbers of nodes removed at different surgical events. Use the codes in Appendix A under the corresponding primary site.

   NOTE: If no regional lymph nodes are identified in the pathology report, **code '00'** even if the surgical procedure includes a lymph node dissection (i.e., modified radical mastectomy) or if the operative report documents removal of nodes.

   EXAMPLE: A patient has a hilar node biopsy for diagnosis and later undergoes Bilobectomy during first course of treatment. Record the number of lymph nodes examined from the Bilobectomy only.

Because this field is not cumulative and not affected by timing issues, it does not replace or duplicate the field "Regional Lymph Nodes Removed". Do not copy the values from one field to the other.

In the Number of Regional Lymph Nodes Removed field, the following priorities apply:

- If lymph node surgery is done at the same time as definitive surgery, priority is given to the information connected with the most definitive surgery. Use the priority order listed under "Surgery of Primary Site" to determine the most definitive surgery of primary site.

- If lymph node surgery is done at a different time from the definitive surgery, priority is given to the code connected with the most definitive lymph node surgery. Use the priority order listed under "Scope of Regional Lymph Node Surgery" to determine the most definitive lymph node surgery.

Coding Instructions for Confidential Cancer Reporting Form, continued

4. Document and code the **SCOPE OF REGIONAL LYMPH NODE SURGERY** using the codes in Appendix A under the corresponding primary site. "Scope of Regional Lymph Node Surgery" defines the removal of regional lymph node(s). There is no minimum number of nodes that must be removed. If at least one regional lymph node was removed, the code for this field must be in the range of *"1"* - *"5"*. If a regional lymph node was aspirated, code the regional lymph node(s) removed, NOS ('1').

For head and neck sites, this field describes neck dissections. Codes '2' - '5' indicate only that a neck dissection procedure was done, they do not imply that nodes were found during the pathologic examination of the surgical specimen. Code the neck dissection even if no nodes were found in the specimen.

The codes are hierarchical. If only one procedure can be recorded, code the procedure that is numerically higher.

> ***EXAMPLE***: A patient with a head and neck primary has a lymph node biopsy (code '1') followed by a limited neck dissection (code '3'). Code the limited neck dissection (code '3'). If a patient has a modified radical neck dissection, record code '4' (modified radical neck dissection) rather than the generic code "neck dissection, NOS" (code '2').

A list identifies the regional lymph nodes for each site in Appendix A. All other nodes are distant and are coded in the data field "surgery of Other Regional Site(s), Distant Site(s) or Distant Lymph Node(s)".

> ***NOTE***: If no cancer-directed procedure was performed code ('0').

In the Scope of Regional Lymph Node Surgery field, the following priorities apply:

- Codes *"1"* -*"8"* have priority over code *"0"* and *"9"*.
- In the range of codes *"1"* - *"8"*, the numerically higher code has priority.

In the absence of surgical procedures of the primary site and regional and/or distant sites, **document** the **non** cancer-directed procedure. Code the surgery and regional and/or distant field "00" and "0" (no surgery performed) respectively and leave the date field empty.

Document and code cancer-directed surgeries, regardless of whether the surgery was performed at your institution or another institution.

If two or more cancer-directed surgeries of the primary site are performed, record the most comprehensive cancer-directed surgery code with the date of the **first** cancer-directed treatment.

> ***EXAMPLES:*** mastectomy, hysterectomy, wide excision, excisional biopsy, fulguration, MOH's technique (chemosurgery)

Coding Instructions for Confidential Cancer Reporting Form, continued

REASON FOR NO CANCER-DIRECTED SURGERY (1340) (ROADS pgs. 196-197) (SEER pg. 133)

Record the code for the reason no cancer-directed surgery was performed. **(Optional Data Set). Data set has to be coded to either a '0' or '9' even if optional.**

CODES	DEFINITION
0	Cancer-directed surgery performed. The field "surgery" is coded in the range 10-90.
1	Cancer-directed surgery not recommended for this stage of disease, histologic type or site.
2	Cancer-directed surgery was contraindicated because of other conditions; or autopsy only cases; cases in which cancer-directed surgery would have been the treatment of choice, but could not be performed because of co-morbid (contraindicated) conditions. Cases in which surgery was recommended, but the patient expired before it could be performed. Autopsy-only cases (class 5).
6	Cancer-directed surgery would have been the treatment of choice; surgery was not performed, but the reason is not given.
7	Cancer-directed surgery was the treatment of choice and recommended by the physician. The patient, patient's guardian or family member refused cancer-directed surgery.
8	Cancer-directed surgery was recommended by a physician; no follow-up information available to confirm if surgery was performed.
9	No cancer-directed surgery known to have been performed; no confirmation if surgery was recommended or performed (frequently non-analytic cases); death certificate-only cases.

DATE STARTED - RADIATION (1210) (ROADS pg. 198)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day and year the **first course** of radiation was initiated. If two or more types of radiation therapy used (i.e., beam and isotopes or beam and implants), record the date of the first type of radiation. If the exact date of radiation therapy is not available, record an approximate date.

TYPE OF RX - RADIATION (1360) (ROADS pg. 199) (SEER pg.134)

Radiation therapy can be administered from either external (i.e., beam) or internal (i.e., radioactive implants) sources.

> ***EXAMPLES****: centigray (cGy), gamma knife, radioactive implants, I-131, seeds, cesium, radioactive gold*

Document and code the type of radiation whether administered to the primary site or a metastatic site.

Coding Instructions for Confidential Cancer Reporting Form, continued

Include all radiation therapy that are a part of the **first course of treatment**, whether delivered at your institution or another institution.

CODES	DEFINITION
0	No radiation therapy was administered.
1	**Beam radiation** was administered**:** x-ray, cobalt, linear accelerator, neutron beam, betatron, spray radiation, intraoperative radiation and stereotactic radiosurgery (gamma knife and proton beam).
2	**Radioactive implants** were administered**:** brachytherapy, interstitial implants, molds, seeds, needles, or intracavitary applicators of radioactive materials (cesium, radium, radon, and radioactive gold).
3	**Radioisotopes** were administered**:** internal use of radioactive isotopes (iodine-131, phosphorus-32, strontium 89 and 90). Radioisotopes can be administered orally, intracavitary, or by intravenous injection.
4	**Combination:** a combination of beam radiation (1) **and** radioactive implants (2), radioisotopes (3) or both were used.
5	Radiation was administered but the method or source is unknown or not documented. NOS
9	Unknown if radiation therapy was administered. Death certificate only cases.

REASON FOR NO RADIATION THERAPY (1430) (ROADS pgs. 225-226) (SEER pg. 135)

Record the reason no radiation therapy was performed. **(Optional Data Set)**
Data set has to be coded to either a '0' or '9' even if optional.

CODES	DEFINITION
0	Radiation therapy was performed as first course of treatment. The field "radiation" was coded 1-5.
1	Radiation therapy was considered but not recommended as appropriate for this stage of disease, histologic type, or site.
2	Cases in which radiation therapy would have been recommended as part of the treatment plan but could not be performed due to co-morbid (contraindicated) conditions; cases in which radiation therapy was recommended, but the patient expired before radiation was given; or autopsy only cases. (Class 5).
6	Radiation therapy was part of the treatment plan, but it was not done and the reason is not given.
7	Radiation therapy was the treatment of choice and was recommended by a physician. The patient, patient's guardian or family member refused radiation treatment.
8	Radiation therapy was recommended. There is no information on whether the patient received radiation treatment.
9	Available medical records do not state whether radiation therapy was considered, consultation performed, treatment recommended or treatment performed; death certificate-only cases.

Coding Instructions for Confidential Cancer Reporting Form, continued

DATE STARTED - CHEMOTHERAPY (1220) (ROADS pg. 227)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day and year the first course of chemotherapy was started. If the exact date of chemotherapy is not available, record an approximate date.

TYPE OF RX - CHEMOTHERAPY (1390) (ROADS pgs. 228-230) (SEER pg. 137)

Chemotherapy is a chemical (or group of chemicals) administered to treat cancer. It does not achieve its effect through hormonal change. Chemotherapy consists of a group of anticancer drugs that inhibit the reproduction of cancer cells by interfering with DNA synthesis and mitosis.

> ***EXAMPLES:*** *CHOP, 5-FU, Adriamycin, Bleomycin, Daunorubicin*
>
> ***NOTE:*** *The Self Instructional Manual for Tumor Registrars, Book 8- Antineoplastic Drugs, that is published by the SEER program, is a* ***recommended reference*** *for the documentation of antineoplastic drugs on the TCR Reporting Form. This resource can be obtained from SEER (refer to page 59 for the mailing address and phone number).*

Document and code the type of chemotherapy administered as **first course of treatment**, whether chemotherapy was given at your institution or another institution.

CODES	DEFINITION
0	No chemotherapy was administered.
1	**Chemotherapy, NOS** was administered
2	**Chemotherapy, single agent** was administered
3	**Chemotherapy, multiple agents** (combination regimen) was administered
9	Unknown if chemotherapy administered; death certificate only cases.

Chemotherapeutic agents may be administered by intravenous infusion or given orally.

Chemotherapy agents are administered in treatment cycles, either singly or in a combination regimen of two or more chemotherapy drugs. The interval of a treatment cycle varies and chemotherapy may be administered for several weeks or several years.

Adjuvant chemotherapy is given after other methods have destroyed the clinically detectable cancer cells. Chemotherapy is given to destroy micrometastasis (undetectable cancer cells). The intent of adjuvant chemotherapy is to prevent or delay a recurrence.

> ***EXAMPLE:*** *The patient has breast cancer with positive nodes. The patient is clinically free of disease after a modified radical mastectomy. The patient is treated with adjuvant chemotherapy to prevent or delay disease recurrence.*

Coding Instructions for Confidential Cancer Reporting Form, continued

Multimodality, combined modality or *concurrent* therapy is chemotherapy given before, during or after other treatment modalities (i.e., surgery, radiation) as a part of the treatment plan.

> ***EXAMPLE:*** *A patient has rectal cancer surgically resected, then undergoes combined radiation therapy and chemotherapy.*

Neo-adjuvant therapy is given prior to surgical resection or radiation therapy to help reduce the bulk of a locally advanced primary cancer.

> ***EXAMPLE:*** A patient with locally advanced breast cancer receives chemotherapy to reduce the tumor size. Chemotherapy is followed by a modified radical mastectomy.

REASON FOR NO CHEMOTHERAPY (1440) (ROADS pg. 236)
Record the code for the reason no cancer-directed surgery was performed. **(Optional Data Set) Data set has to be coded to either a '0' or '9' even if optional.**

CODES	DEFINITION
0	Chemotherapy was administered. The field "chemotherapy" was coded 1-3.
1	Chemotherapy is not the method recommended for this stage of disease, histologic type, or site.
2	Cases in which chemotherapy would have been the treatment of choice, but could not be performed because of co-morbid (contraindicated) conditions; cases in which chemotherapy was recommended, but the patient expired before the treatment could begin; or autopsy only cases.
6	Chemotherapy would have been the treatment of choice but was not administered; the reason is not documented.
7	Chemotherapy was the treatment of choice and was recommended by a physician. The patient, patient's guardian or family member refused chemotherapy.
8	Chemotherapy was recommended by a physician; no follow-up information available to confirm if chemotherapy was administered.
9	No confirmation if chemotherapy was recommended or administered (frequently non-analytic cases); death certificate-only cases.

DATE STARTED - HORMONE THERAPY (1230) (ROADS pg. 237)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day and year the first course of hormone therapy was initiated. If the exact date of hormone therapy is unknown, record an approximate date.

TYPE OF RX - HORMONE/STEROID (ENDOCRINE) THERAPY (1400)
(ROADS pgs. 238-239) (SEER pg. 138)

Hormone therapy is administered to treat cancer tissue and is considered to achieve its effect through change of the hormone balance. Some tissues, such as prostate or breast, depend upon hormones to develop. When a malignancy arises in these tissues, it is usually hormone-responsive. Other

Coding Instructions for Confidential Cancer Reporting Form, continued

primaries and histologic types may be hormone-responsive, such as melanoma and hypernephroma. Hormonal therapy may effect a long-term control of the cancer growth. It is usually not used to "cure" the cancer.

> ***EXAMPLES:*** *Tamoxifen; orchiectomy for prostate cancer; oophorectomy for breast cancer; adrenalectomy; hypophysectomy; radiation to ovaries for breast cancer or testicles for prostate cancer*

Document and code the type of hormone therapy the patient received as part of the **first course of treatment**, whether the patient received the hormones at your institution or another institution.

CODES	DEFINITION
0	No hormone was administered.
1	**Hormonal therapy** (including NOS and antihormones).
2	**Endocrine surgery** and/or **endocrine radiation therapy** (i.e., oophorectomy for breast cases; orchiectomy for prostate cases).
3	**Combination** of 1 and 2.
9	Unknown if hormonal therapy administered; death certificate only cases.

Record prednisone as hormonal therapy when administered in combination with chemotherapy, such as MOPP (mechlorethamine, vincristine, procarbazine, prednisone) or COPP (cyclophosphamide, vincristine, procarbazine, prednisone).

> ***EXCEPTION:*** *When prednisone or other hormone is administered for other reasons, do not code as hormone therapy.*

Decadron is coded as definitive cancer treatment for **leukemias**, **lymphomas**, and **multiple myelomas**. ***Decadron*** is administered in order to achieve its effect on cancer tissue through change of the hormone balance. It is coded for **other sites** only when stated to be **cancer directed treatment**.

> ***EXAMPLES:*** *A patient has advanced lung cancer with multiple metastasis to the brain. The physician orders decadron to reduce the edema in the brain and relieve the neurological symptoms. Decadron is not coded as hormone therapy.*
>
> *A patient with advanced disease is given prednisone to stimulate the appetite and improve nutritional status. Do not code the prednisone as hormone therapy.*

Coding Instructions for Confidential Cancer Reporting Form, continued

REASON FOR NO HORMONE THERAPY (1450) (ROADS pg. 241)

Record the reason no hormone therapy was performed. **(Optional Data Set)**
Data set has to be coded to either a '0' or '9' even if optional.

CODES	DEFINITION
0	Hormone therapy was given.
1	Hormone therapy is not the method recommended for this stage of disease, histology or site.
2	Cases in which hormone therapy would have been the treatment of choice, but could not be administered because of co-morbid (contraindicated) conditions; cases in which hormone therapy was recommended, but the patient expired before therapy was administered; or autopsy only cases.
6	Hormone therapy would have been the treatment of choice, but was not administered. The reason is not documented.
7	Hormone therapy was the treatment of choice and was recommended by the physician. The patient, patient's guardian or family member refused hormone therapy.
8	Hormone therapy was recommended, but no information is available about whether the patient received hormones.
9	No confirmation if hormone therapy was recommended or administered (frequently non-analytic cases); death certificate-only cases.

DATE STARTED - BIOLOGICAL RESPONSE MODIFIER (BRM) (1240) (ROADS pg. 242)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day and year the first course of BRM (immunotherapy) was started. If the exact date of BRM is not available, record an approximate date.

TYPE OF RX - BRM (1410) (ROADS pg. 243) (SEER pg. 139)

Immunotherapy consists of biological or chemical agents that alter the immune system or change the host's response to the tumor cells.

> ***EXAMPLES:*** *BCG, Bone marrow transplant, C-Parvum, Interferon, Interleukin, Levamisole, MVE-2, Pyran copolymer, Thymosin, Vaccine therapy, Virus therapy, ASILI (active specific intralymphatic immunotherapy), Blocking factors, I-131 - labeled immunoglobin (also code as Radioisotopes under the radiation treatment)*

Coding Instructions for Confidential Cancer Reporting Form, continued

Document and code the BRM the patient received as part of the **first course of treatment**, whether the BRM was given at your institution or another institution.

CODES	DEFINITION
0	No biological response modifier was administered.
1	Biological response modifier
2*	Bone marrow transplant - autologous
3*	Bone marrow transplant - allogeneic
4*	Bone marrow transplant, NOS
5*	Stem cell transplant
6*	Combination of 1 and any 2, 3, 4, or 5
7	Patient or patient's guardian refused BRM
8	BRM recommended, unknown if administered
9	No confirmation if BRM was recommended or performed; unknown if BRM administered; death certificate only cases.

***NOTE:** *Codes 2-6 are effective for cases diagnosed 1996 and forward.*

DATE STARTED - OTHER (1250) (ROADS pg. 245)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day and year the first course of other treatment was started. If the exact date of other treatment is not available, record an approximate date.

TYPE OF RX - OTHER (1420) (ROADS pgs. 246-247) (SEER pg. 140)

"Other treatment" includes therapies designed to modify or control the cancer cells that are not defined in "Surgery", "Radiation", "Chemotherapy", or "Hormone Therapy" fields. This includes experimental, unproven, or newly developed methods.

***EXAMPLES:** Laetrile, Krebiozen, Hyperthermia, Arterial block for renal carcinoma*

Do **NOT** code ancillary drugs in this field. There is no coding scheme for ancillary drugs.

***EXAMPLES:** Allopurinol, G-CSF (growth stimulating factor), Epogen, Neupogen*

Coding Instructions for Confidential Cancer Reporting Form, continued

For NRHD only, code "non-cancer directed" treatment as "1" under "Other Rx". (See italicized examples). Documentation should be provided under "Treatment". "Non-Cancer Directed Treatment" is therapy that prolongs the patient's life, alleviates pain, relieves symptoms, makes the patient comfortable, or minimizes the effects of the cancer, but not meant to destroy or control the tumor or delay the spread of disease.

EXAMPLES: *Transfusions (Refractory Anemia), Phlebotomy/blood removal (Polycythemia Vera), and aspirin (Essential Thrombocythemia).*

CODES	DEFINITION
0	All cancer-directed therapy was coded in other treatment fields; the patient received no cancer-directed therapy
1	Other cancer-directed therapy; cancer-directed therapy that cannot be appropriately assigned to other specific treatment codes. For example: Hyperbaric oxygen (as adjunct to cancer-directed treatment) or hyperthermia.
2	Other experimental cancer-directed therapy (not included elsewhere)
3	Double-blind study, code not yet broken
6	Unproven therapy (including laetrile, krebiozen, etc.)
7	Patient or patient's guardian refused therapy which would have been coded 1-3 above
8	Other cancer-directed therapy recommended, unknown if administered
9	Unknown if other cancer-directed therapy administered; death certificate only cases.

TREATMENT DOCUMENTATION (2610, 2620, 2630, 2640, 2650, 2660, 2670)

Text information to support cancer diagnosis, stage and treatment codes must be provided by facilities without a ***documented data quality program*** such as one approved by the American College of Surgeons. Document any and all types of **first course** definitive treatment administered regardless of where the treatment was received (at the reporting institution or another facility) or whether or not you have coded it above, along with the date the treatment was received or begun.

Also, document in this section if the medical record indicates no treatment was given (0's entered for Type of Treatment) or if there is information in the medical record that definitive first course treatment was given but the exact treatment modality is unknown, document (9's entered for Type of Treatment).

If it cannot be determined whether an intended therapy was actually performed, record that it was recommended but it is not known if the procedure was administered. For example, "chemotherapy recommended; unknown if given," (8 entered for Type of Treatment).

NOTE: *Supportive Care (Refractory Anemia with Sideroblasts) and Observation (Chronic Myeloproliferative Disorder) should be documented.*

Coding Instructions for Confidential Cancer Reporting Form, continued

DATE OF LAST CONTACT OR DATE OF DEATH (MMDDYYYY) (1750) (ROADS pg. 263) (SEER pg. 144)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day, and year (MMDDYYYY) of the date of last contact, or if patient is deceased, record the date of death. Record the date last seen at your facility or date of last contact from follow up information on the patient. If patient is known to be deceased, but date of death is not available, the vital status should be coded alive (1) and the date of last contact should be recorded in this field. Under the Other Pertinent Information text area, document the patient is deceased and the date of death is not available. The TCR will research the Bureau of Vital Statistics death files to obtain date of death.

VITAL STATUS (1760) (ROADS pg. 264) (SEER pg. 145)

Code the patient's vital status as of the date recorded in the "Date of Last Contact or Death" field. Use the most current and accurate information available.

NOTE: If a patient has multiple primaries, all records should have the same vital status.

Codes:

0 Dead
1 Alive

CAUSE OF DEATH (1910) (ROADS pg. 271) (SEER pg. 147)

The underlying cause of death will be coded by the TCR using information from the Bureau of Vital Statistics and the National Death Index. The cause of death is not available for release until appropriate approval is obtained.

DATE ABSTRACTED (MMDDYYYY) (2090)

Punctuation marks (slashes, dashes, etc) are not allowed in *any* date field.

Record the month, day, full year the form was completed.

ABSTRACTOR INITIALS (570) (ROADS pg. 89)

Record the initials of the abstractor.

NAACCR RECORD VERSION (50)

TCR will code this field.